STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155764	A. BUILDING B. WING		10/23/2012
	NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			ADDRESS, CITY, STATE, ZIP CODE 87TH AVE ILLVILLE, IN 46410	•
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	Complaints IN0 IN00118202. This resulted in survey- Past No Jeopardy. Complaint IN00 Federal/state de allegations are cand F999. Complaint IN00 Federal/state de	a partially extended in Compliance Immediate 0117692-Substantiated. fficiencies related to the sited at F329, F333, F505, 0118202-Substantiated. fficiencies related to the ited at F329, F333, and 2 y date: 2 :: 010739 er: 155764 200856890	F0000		
	SNF/NF: 5				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

TITLE

PRINTED: 11/30/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 155764	(X2) MULTIPLE CO A. BUILDING B. WING	00	10/23	SURVEY LETED 5/2012
	PROVIDER OR SUPPLIER MILL HEALTH CAMPUS	101 W 8	ADDRESS, CITY, STATE, ZIP COD 37TH AVE LLVILLE, IN 46410	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	Residential: 64 Total: 118				
	Census payor type: Medicare: 42 Medicaid: 5 Other: 71 Total: 118 Sample: 6 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on October 26, 2012 by Bev Faulkner, RN				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YNB211

Facility ID: 010739

If continuation sheet

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CO	NSTRUCTION 00	(X3) DATE S COMPLI	
AND LAN	or connection	155764	A. BUILD	ING		10/23/	
		100701	B. WING	CED FEET A	DDDEGG GUTY GTATE GUD	10/20/	2012
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
SPRING	MILL HEALTH CAN	MPUS .			LVILLE, IN 46410		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0329 SS=J	from unnecessary drug is any drug with dose (including disexcessive duration monitoring; or with for its use; or in the consequences which should be reduced combinations of the Based on a compresident, the faciliar residents who have drugs are not given antipsychotic drug treat a specific condocumented in the residents who use receive gradual dephavioral interversidents who use r	DRUGS rug regimen must be free rug rug. An unnecessary when used in excessive uplicate therapy); or for n; or without adequate hout adequate indications ne presence of adverse nich indicate the dose d or discontinued; or any ne reasons above. rehensive assessment of a tty must ensure that we not used antipsychotic en these drugs unless g therapy is necessary to indition as diagnosed and e clinical record; and e antipsychotic drugs ose reductions, and entions, unless clinically in an effort to discontinue review and interview, the ensure monitoring related acting upon laboratory ittic levels was in place in e potential adverse d failed to ensure the f the correct dose of an edication, which resulted all bleeding requiring or 1 of 3 residents use of anti-coagulant	F0329		Past non-compliance POC not required.		11/22/2012
		-					

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Event ID: YNB211

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If continuation sheet

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PRINTED: 11/30/2012 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE : COMPL	
		155764		LDING		10/23/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER				37TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Due to the lack o	of monitoring this					
		e had the potential to					
		esidents receiving					
		erapy of the 54 residents					
	_	ealth care units of the					
	_	e total 118 residents					
	residing in the fa						
		,					
	The Immediate J	eopardy began on					
	10/8/12 when Re	esident #E received the					
	incorrect dose of	Coumadin (an					
	anticoagulant me	edication) and the error					
	was not identifie	d until 10/11/12 when the					
	resident develop	ed an onset of					
	_	oleeding requiring the					
	_	or the transfusion of fresh					
		lood product to maintain					
		ne facility Interim					
		tor, Clinical Support					
		isk Management Nurse					
		f the Immediate Jeopardy					
		1:00 a.m. The Immediate					
		moved and the deficient					
	_	d on 10/12/12, prior to					
		arvey and was therefore					
	Past Noncomplia	ance.					
	Findings include	·					
	i mamgs merade	•					
	The record for R	esident #E was reviewed					
		0:30 a.m. The resident's					
		ed, but were not limited					
	~	renal failure, high blood					
	, , , , , , , , , , , , , , , , , , ,	, 3					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YNB211

Facility ID: 010739

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764			LDING	NSTRUCTION 00	(X3) DATE COMPL 10/23	ETED	
	PROVIDER OR SUPPLIER			101 W 8	DDRESS, CITY, STATE, ZIP CODE 37TH AVE LVILLE, IN 46410	•	
(X4) ID PREFIX	SUMMARY S	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	$\overline{}$	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F	Ε	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
	admitted to the f	hritis. The resident was acility on 10/3/12. The to the hospital on s readmitted to the /12.					
	indicated there w	0/12 Physician orders was an order written on esident to receive					
	Coumadin (a me clotting risk) 2 n evening at 5:00 p	dication to prevent blood nilligrams orally every o.m. An order was					
	weekly PT/INR Another order w	2 for the resident to have laboratory levels drawn. as written on 10/4/12 to					
	10/4/12 for one of	lin 2 milligrams on lay and then begin igram daily. There was					
		tten on 10/4/12 to obtain					
		(Medication Record) was reviewed. ted the resident was					
	_	ndin for a diagnosis of (an irregular heartbeat).					
	milligrams was of 10/4/12 and circle	eircled as not given on ed with the word "hold"					
	though the colun "d/c 10/4/12 see						
	handwritten acro There was a hand	ss the column. d written entry on second					

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Event ID: YNB211

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155764	B. WIN			10/23/	2012
NAMEORY	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER				B7TH AVE		
	MILL HEALTH CAN			<u> </u>	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAU		,	+	IAU			DATE
	1	R for Coumadin 1					
	1	to be given daily at 5:00					
		ation was signed out as					
	1	0/7/12, 10/8/12, and					
		o.m. Vitamin K 5					
	_	vas also signed out as					
	given on 10/10/1	12 at 4:00 p.m.					
	Review of the la	boratory test results					
		NR test was completed on					
		sults were PT 35.6 and					
		boratory results indicated					
		as notified of the above					
	_	2 and Physician orders					
		old the Coumadin 2					
		e day and then start					
	_	ligram daily. There was					
		obtain another PT/INR					
		n 10/8/12. A PT/INR was					
	<u> </u>	0/8/12. The results were					
	_	R 4.4. There was no					
		of the Physician being 0/8/12 results. A weekly					
		•					
		npleted on 10/10/12 based					
	1	order for PT/INR levels					
	_	weekly. The results of					
		/INR were noted to be a					
		The results were PT					
	118.8 and INR 1	2.8.					
	Review of the 12	2th Edition of the					
	"Geriatric Dosag	ge Handbook" included					
	_	ed on indication of use					
	_	e targeted INR for the					
							I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YNB211

Facility ID: 010739

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PRINTED: 11/30/2012 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS SIRREL ADDRESS, CITY, STATE, ZIP CODE 101 W 37TH AVE MERRILLVILLE, IN 46410 SIMMARY STRIBMIN OF DIRECTIONS TAG SIRREL ADDRESS, CITY, STATE, ZIP CODE 101 W 37TH AVE MERRILLVILLE, IN 46410 IN A 37TH AVE REGULATORY OR I.S. DIRECTIONS OR SUPPLIE TAG THE October 2012 Lab tracking Forms were reviewed. Resident name, test ordered, date to be done, date completed, date results returned, physician notification, responsible party notification and comments were to be filled out for each laboratory test ordered for each resident. The form indicated Resident #E was to have PT/INR laboratory tests drawn on 104/12, 104/1012, 104/17/12, 107/24/12, and 107/31/12. The log did not list the PT/INR ordered on 104/12. The resident's name, test, and test dates were the only lines completed on the log. The other columns listed above were blank. The PT/INR ordered to be completed on 10/8/12 was not on the log. The other columns listed above were blank. The PT/INR ordered to be completed on 10/8/12 was not on the log. The other columns listed above were blank. The PT/INR ordered to be completed on 10/8/12 was not on the log. The other columns listed above were blank. The PT/INR ordered to be completed on 10/8/12 was not on the log. The other columns listed above were blank. The PT/INR ordered to be completed on 10/8/12 was not on the log. The other columns listed above were blank. The PT/INR ordered to be completed on 10/8/12 was not on the log. The other columns listed above were listed on the log. The 10/12 Nurses' Notes were reviewed. A late entry for 10/10/12 (no time listed) indicated the the Physician was made of aware of the Critical laboratory test results and orders were received to administer Vitamin K (a medication used to decrease the effects of Coumadin) 5 milligrams IM (intramuscularly) one time and to hold Coumadin until further notice. The entry also indicated no breakthrough	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
STRIET ADDRESS, CITY, STATE, ZIP CODE. 101 W 87TH AVE MERRILLYILLE, IN 46410 SUMMARY STATEMENT OF DEPICIENCIES PREFIX (EACH DEPICIENCY MUST BE PRECEDED BY PULL TAG REGULATORY OR ISC IDENTIFYING INFORMATION) Treatment of airial fibrillation was 2.5 with a targeted range of 2.0-3.0. The October 2012 Lab tracking Forms were reviewed. Resident name, test ordered, date to be done, date completed, date results returned, physician notification, responsible party notification and comments were to be filled out for each laboratory test ordered for each resident. The form indicated Resident #E was to have PT/INR laboratory tests drawn on 104/12, 10/10/12, 10/17/12, 10/24/12, and 10/31/12. The log did not list the PT/INR ordered on 10/4/12. The resident's name, test, and test dates were the only lines completed on the log. The other columns listed above were blank. The PT/INR ordered to be completed on 10/8/12 was not on the log. The results of the 10/4/12 PT/INR were not listed on the log. The 10/12 Nurses' Notes were reviewed. A late entry for 10/10/12 (no time listed) indicated the the Physician was made of aware of the Critical laboratory test results and orders were received to administer Vitamin K (a medication used to decrease the effects of Coumadin) 5 milligrams IM (intramuscularly) one time and to hold Coumadin until further notice. The entry also indicated no breakthrough	MULLAN				
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SPRING MILL HEALTH CAMPUS MERRILLVILLE, IN 46410	NAME OF I	PROVIDER OR SUPPLIER			
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each laboratory test ordered for each resident. The form indicated Resident #E was to have PT/INR laboratory tests drawn on 10/4/12, 10/10/12, 10/17/12, 10/24/12, and 10/31/12. The log did not list the PT/INR ordered on 10/4/12. The resident's name, test, and test dates were the only lines completed on the log. The other columns listed above were blank. The PT/INR ordered to be completed on 10/8/12 was not on the log. The results of the 10/4/12 PT/INR were not listed on the log. The 10/12 Nurses' Notes were reviewed. A late entry for 10/10/12 (no time listed) indicated the the Physician was made of aware of the Critical laboratory test results and orders were received to administer Vitamin K (a medication used to decrease the effects of Coumadin) 5 milligrams IM (intramuscularly) one time and to hold Coumadin until further notice. The entry also indicated no breakthrough		notification, responsible party notification			
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was to have PT/INR laboratory tests drawn on 10/4/12, 10/10/12, 10/17/12, 10/24/12, and 10/31/12. The log did not list the PT/INR ordered on 10/4/12. The resident's name, test, and test dates were the only lines completed on the log. The other columns listed above were blank. The PT/INR ordered to be completed on 10/8/12 was not on the log. The results of the 10/4/12 PT/INR were not listed on the log. The 10/12 Nurses' Notes were reviewed. A late entry for 10/10/12 (no time listed) indicated the the Physician was made of aware of the Critical laboratory test results and orders were received to administer Vitamin K (a medication used to decrease the effects of Coumadin) 5 milligrams IM (intramuscularly) one time and to hold Coumadin until further notice. The entry also indicated no breakthrough		each laboratory test ordered for each			
drawn on 10/4/12, 10/10/12, 10/17/12, 10/24/12, and 10/31/12. The log did not list the PT/INR ordered on 10/4/12. The resident's name, test, and test dates were the only lines completed on the log. The other columns listed above were blank. The PT/INR ordered to be completed on 10/8/12 was not on the log. The results of the 10/4/12 PT/INR were not listed on the log. The 10/12 Nurses' Notes were reviewed. A late entry for 10/10/12 (no time listed) indicated the the Physician was made of aware of the Critical laboratory test results and orders were received to administer Vitamin K (a medication used to decrease the effects of Coumadin) 5 milligrams IM (intramuscularly) one time and to hold Coumadin until further notice. The entry also indicated no breakthrough		resident. The form indicated Resident #E			
10/24/12, and 10/31/12. The log did not list the PT/INR ordered on 10/4/12. The resident's name, test, and test dates were the only lines completed on the log. The other columns listed above were blank. The PT/INR ordered to be completed on 10/8/12 was not on the log. The results of the 10/4/12 PT/INR were not listed on the log. The 10/12 Nurses' Notes were reviewed. A late entry for 10/10/12 (no time listed) indicated the the Physician was made of aware of the Critical laboratory test results and orders were received to administer Vitamin K (a medication used to decrease the effects of Coumadin) 5 milligrams IM (intramuscularly) one time and to hold Coumadin until further notice. The entry also indicated no breakthrough		was to have PT/INR laboratory tests			
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resident's name, test, and test dates were the only lines completed on the log. The other columns listed above were blank. The PT/INR ordered to be completed on 10/8/12 was not on the log. The results of the 10/4/12 PT/INR were not listed on the log. The 10/12 Nurses' Notes were reviewed. A late entry for 10/10/12 (no time listed) indicated the the Physician was made of aware of the Critical laboratory test results and orders were received to administer Vitamin K (a medication used to decrease the effects of Coumadin) 5 milligrams IM (intramuscularly) one time and to hold Coumadin until further notice. The entry also indicated no breakthrough					
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aware of the Critical laboratory test results and orders were received to administer Vitamin K (a medication used to decrease the effects of Coumadin) 5 milligrams IM (intramuscularly) one time and to hold Coumadin until further notice. The entry also indicated no breakthrough		A late entry for 10/10/12 (no time listed)			
results and orders were received to administer Vitamin K (a medication used to decrease the effects of Coumadin) 5 milligrams IM (intramuscularly) one time and to hold Coumadin until further notice. The entry also indicated no breakthrough		indicated the the Physician was made of			
administer Vitamin K (a medication used to decrease the effects of Coumadin) 5 milligrams IM (intramuscularly) one time and to hold Coumadin until further notice. The entry also indicated no breakthrough		aware of the Critical laboratory test			
to decrease the effects of Coumadin) 5 milligrams IM (intramuscularly) one time and to hold Coumadin until further notice. The entry also indicated no breakthrough		results and orders were received to			
milligrams IM (intramuscularly) one time and to hold Coumadin until further notice. The entry also indicated no breakthrough		administer Vitamin K (a medication used			
and to hold Coumadin until further notice. The entry also indicated no breakthrough		to decrease the effects of Coumadin) 5			
The entry also indicated no breakthrough		milligrams IM (intramuscularly) one time			
		and to hold Coumadin until further notice.			
bleeding or gastrointestinal bleeding was		,			
		bleeding or gastrointestinal bleeding was			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764		A. BUILDING B. WING	00 	COMPLE S 10/23/2	TED
	PROVIDER OR SUPPLIER MILL HEALTH CAMPUS	101 W 8	DDRESS, CITY, STATE, ZIP CODE 87TH AVE LVILLE, IN 46410		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	noted. An entry made on 10/11/12 at 2:00 p.m., indicated the resident had a large amount of blood noted in the stool and the resident was sent to the hospital 911.				
	When interviewed on 10/22/12 at 1:00 p.m., the Risk Management RN indicated Resident #E was sent to the hospital on 10/11/12. The RN indicated the facility started doing a change of condition audit related to the hospitalization. The RN indicated she audits were done on 10/11/12 and she believed this to be when the facility determined the Physician was not notified of the 10/8/12 PT/INR results.				
	When interviewed on 10/22/12 at 1:04 p.m., the Clinical Support Nurse indicated the Physician is to be called with abnormal lab results. The Nurse indicated laboratory requisitions were to be brought to Morning Meeting and reviewed. The Unit Manager is then to follow up and ensure the test is completed and follow up is provided. The RN also indicated there is a binder at each Nurses' station with "Lab Tracking" forms. The resident's name, test ordered, date completed, date results returned, MD notification, Responsible Party notification, and other comments are to be recorded on the monthly log. The Nurse indicated if there was a Morning Meeting on 10/8/12 this				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155764	B. WIN	G		10/23/	2012
NAME OF F	PROVIDER OR SUPPLIER	_		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					B7TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		8/12 lab test should have					
		nd follow up including					
	_	, completing notification					
	should have been	n done.					
		ed on 10/23/12 at 8:00					
	a.m., the Clinical	Support Nurse indicated					
	when investigating	ng the resident's					
	hospitalization a	nd elevated PT/INR level					
	it appeared the N	Iurses may have					
	interpreted the w	ritten order on the MAR					
	for 1 milligram o	of Coumadin to be 7					
	milligrams. The	Nurse indicated they					
	reviewed the resi	ident's orders, pharmacy					
	punch cards, and	the MAR. The Nurse					
	indicated staff w	orking on this shift the					
		3/12 were interviewed.					
	The facility inve	stigation concluded the					
		Coumadin 1 milligram					
		0/7/12 and 7 milligrams					
		0/9/12 resulting in the					
	resident's PT/INI	•					
		ne Nurse indicated LPN					
		12 and 10/9/12 and					
		oses of Coumadin on					
	_	The Nurse indicated we					
	I	eror on 10/11/12 when					
		g done on resident's					
	· ·	-					
	receiving Couma	IUIII.					
	When interview	ed on 10/23/12 at 9:30					
		anagement Nurse					
	· ·	•					
		ning Meeting was held on					
	10/8/12 and no n	neeting was held on					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	ONSTRUCTION 00	(X3) DATE COMP	E SURVEY LETED	
		155764	A. BUILDING B. WING	-	10/23	3/2012
	PROVIDER OR SUPPLIE		STREET A 101 W 8	ADDRESS, CITY, STATE, ZIP CO 87TH AVE LLVILLE, IN 46410	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Jeopardy began Immediate Jeop deficient practic after the facility plan that include completion of at Administration orders, laborator verification of the Medication of residents curren The facility also individual Coag placed in the Me residents.	mpliance Immediate on 10/8/12. The ardy was removed and the e corrected by 10/12/12 implemented a systemic ed the following actions: adits of Medication Records, Physician ry test results, and he correct medications in Carts for 13 of 13 tly receiving Coumadin. Implemented the use of all ulation Records to be redication Books for the 13 relates to Complaints d IN00118202.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		155764	B. WIN			10/23/	2012
			B. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				87TH AVE		
SPRING	MILL HEALTH CAN	MPUS .			LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0333 SS=G	483.25(m)(2) RESIDENTS FREE ERRORS The facility must of free of any significant related to the adranticoagulant (modications to comedications for 20 for medications for 20 for medications for 20 for medication endications after recording	ensure that residents are cant medication errors. review and interview, the ensure residents were at medication errors ministration of edications to prevent and anticonvulsant control seizure activity) 2 of 6 residents reviewed errors in the sample of 6. The hospitalization for one reloped gastrointestinal ceiving the incorrect dose ant medication. and #E) The Resident #E was 22/12 at 10:30 a.m. The sees included, but were colon cancer, renal failure, ture, and arthritis. The mitted to the facility on sident was sent to the 1/12 and was readmitted	F03		F 333 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident E was readmitted to facility on 10.30.12 and is not receiving any Coumadin. Resident D Tegretol medications were reviewed with physician on 10.8.12 for clarification and noted. Identification of other residents having the potentiat to be affected by the same alleged deficient practice and corrective actions taken: All current residents receiving Coumadin were audited on 10.11.12 to ensure dosage of Coumadin and PT/INR laboratory orders for monitoring of Coumadin were conducted as ordered, result communicated to physician and changes implemented as ordered. Current residents an ot receiving Tegretol except for Resident D. Measures printo place and systemic changes made to ensure the alleged deficient practice does not recur: Licensed nurses have been inserviced to write Coumadin orders numerically and alphabetically write out to	e s see t tut	11/22/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155764	B. WIN	G		10/23/2012
NAME OF P	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
TWINE OF T	KOVIDEK OK GOLTEIEK				87TH AVE	
SPRING	MILL HEALTH CAN	MPUS		MERRII	LLVILLE, IN 46410	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Coumadin (a me	dication to prevent blood			dosage in milligrams.	
	clotting risk) 2 m	nilligrams orally every			Inserviced on PT/INR form o	n
	evening at 5:00 p	o.m. An order was			when lab to be drawn.	
		12 for the resident to have			Licensed nurses have been	
		laboratory levels drawn			inserviced on medication past procedures and error	,s
	1	r order was written on			prevention. How the corrective	ve
	10/4/12 to hold t				measures will be monitored t	
					ensure the alleged deficient	
	_	0/4/12 for one day and			practice does not recur:	
	_	nadin 1 milligram daily.			Director of nursing/designee	
There was also an order written on				will monitor by using an audi	t	
	10/4/12 to obtain a PT/INR on 10/8/12.				tool Coumadin and PT/INR	
					daily for 90 days, then five	
	The 10/12 MAR	(Medication			days a week for 60days, the	
	Administration F	Record) was reviewed.			three days a week for 30 day Audits will be reviewed in	s.
	The ordered dose	<i>'</i>			Quality Assurance meeting	
		rcled as not given on			monthly times six months un	til
	_	led with the word "hold"			substantial compliance is	
		re was hand written line			achieved. Director of	
					nursing/designee will do	
	_	nns with the dates and			medication pass competenci	es
	"d/c 10/4/12 see				with three nurses weekly for	
	handwritten acro	ss the column. There			days, then 2 nurses weekly fe	
	was a hand writt	en entry on second page			90 days. Competencies will b	е
	of the MAR for 0	Coumadin 1 milligram			reviewed during Quality	
	orally to be given	n daily at 5:00 p.m. The			Assurance meeting monthly months until substantial	SIX
	medication was s	signed out as given			compliance is achieved. Date	. .
		, 10/8/12, and 10/9/12 at			November 22, 2012	•
		nin K 5 milligrams IM				
	-	out as given on 10/10/12				
	_	out as given on 10/10/12				
	at 4:00 p.m.					
	Review of the la	boratory test results				
		_				
		NR test was completed on				
		alts were PT 35.6 and				
	INR 3.5. The lat	boratory results indicated				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	LDING	NSTRUCTION 00	(X3) DATE COMPL 10/23/	ETED
	PROVIDER OR SUPPLIER		101 W 8	ODDRESS, CITY, STATE, ZIP CODE B7TH AVE LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	results on 10/4/1 were given to ho milligram for on Coumadin 1 millialso an order to claboratory test or completed on 10 PT 44.0 and INR documentation on the Physician to be completed the 10/10/12 PT/a "Critical" level 118.8 and INR 1 The 10/12 Nurse A late entry for 1 indicated the the aware of the Critical to decrease the emilligrams IM (in and to hold Courmentry also in bleeding or gastinoted. An entry p.m., indicated the amount of blood	as notified of the above 2 and Physician orders ld the Coumadin 2 e day and then start ligram daily. There was obtain another PT/INR in 10/8/12. A PT/INR was /8/12. The results were 2.4.4. There was no f the Physician being 0/8/12 results. A weekly inpleted on 10/10/12 based order for PT/INR levels weekly. The results of INR were noted to be at . The results were PT 2.8. Is' Notes were reviewed. 10/10/12 (no time listed) Physician was made of ical laboratory test is were received to min K (a medication used affects of Coumadin) 5 intramuscularly) one time madin until further notice. Indicated no breakthrough cointestinal bleeding was made on 10/11/12 at 2:00 me resident had a large noted in the stool and the it to the hospital 911.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764			LDING	NSTRUCTION 00	(X3) DATE COMPL 10/23	ETED	
	PROVIDER OR SUPPLIER		B. WIIV	STREET A	DDRESS, CITY, STATE, ZIP CODE B7TH AVE LVILLE, IN 46410	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	When interviewed a.m., the Clinical when investigation a it appeared the North interpreted the way for 1 milligrams. The reviewed the respunch cards, and indicated staff whose to 10/6/12 thru 10/8/12 thru 10/8/12 and 1 on 10/8/12 and 1 on 10/8/12 and 1 resident's PT/INI significantly. The significantly was in 10/11/12 when on residents received on 10/11/12 when on resident's diagnor not limited to, en failure, dementiant the resident was 9/20/12 and was in 9/24/12.	ed on 10/23/12 at 8:00 I Support Nurse indicated ing the resident's and elevated PT/INR level surses may have written order on the MAR of Coumadin to be 7 Nurse indicated they ident's orders, pharmacy it the MAR. The Nurse orking on this shift the IS/12 were interviewed. Stigation concluded the I Coumadin 1 milligram 0/7/12 and 7 milligrams 0/9/12 resulting in the					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		LDING	NSTRUCTION 00	(X3) DATE COMPI 10/23	
	PROVIDER OR SUPPLIER		p. wii.	101 W 8	.DDRESS, CITY, STATE, ZIP CODE 87TH AVE LLVILLE, IN 46410	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE	(X5) COMPLETION DATE
	on 9/20/12 at 7:4 CNA notified the was having a seit resident was note seizure. The Physorders were rece to the Emergency of	22 a.m., indicated the e Nurse that the resident zure and at 8:03 a.m., the ed to have another visician was notified and lived to send the resident y Room at the hospital. 27/22 MAR (Medication Record) indicated there is order for the resident to (a medication to control 100 milligrams/5 mls 25 mls orally three times instration times were to the thing, and his (hour of medication was signed out 17/1/12 lunch time through the rising times. The order then on 9/24/12. The listed Carbamazepine for Tegretol) 100 mg. Directly below the tol 100 mg tablet - give 4 dery bedtime for 90 days medication was signed editime 10/1/12 through AR indicated the initial samazepine order was					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155764	B. WING	G		10/23/	2012
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					87TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRII	LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ery bedtime appeared on					
	*	Statement. Marked over					
		iting which indicated the					
	order had been c	hanged on 9/24/12.					
	Review of the la	boratory tests results					
		etol level was obtained on					
		evel was 11.7. The					
		was listed to be (8-12).					
	therapeutic level	was listed to be (0-12).					
	When interviewe	ed on 10/23/12 at 12:10					
	p.m., the Interim	Director of Nursing					
	indicated she me	et with Resident #D's					
	family on Monda	ay 10/8/12. She indicated					
	<u>-</u>	d concerns related to					
	observing a Nurs	se starting to administer					
	_	the resident on 10/7/12					
		pposed to receive the					
		iquid form. The Interim					
	Director of Nurs	ing indicated she					
	reviewed the res	ident's record and					
	medications and	determined there was a					
	medication error	. The Interim Director of					
	Nursing indicate	d the resident had been					
		ol in both the pill form					
	1	rm at night from 10/1/12					
	_	due to a transcription					
	_	m Director of Nursing					
		rse did not administer					
	both the pill form	n and the liquid form of					
	_	0/7/12. She indicated					
	_	art was checked and both					
		nd Tegretol pills were in					
		o indicated the Nurse					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764		A. BUILDING B. WING	COMPLETED 10/23/2012
	ROVIDER OR SUPPLIER MILL HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTION CORRECTION CONTROL OF CONTROL O	E COMPLETION
	who worked on the 10/7/12 did not document anything about the doses nor did the Nurse notify her of the discrepancy on 10/7/12. The Interim Director of Nursing indicated she informed the Physician of the medication error on 10/8/12 and clarified the order for the medication. She also indicated the resident was noted to be lethargic on 10/10/12 and the Physician was notified and a Tegretol level was ordered. The Interim Director of Nursing indicated the 10/10/12 level was normal. This federal tag relates to Complaints IN00117692 and IN00118202. 3.1-48(c)(2)		

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Event ID: YNB211

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A DULLI DINIC OO COMPLET			ETED	
		155764	A. BUILDING 10/23/2012				2012
			B. WIN				
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ODDINO	NAUL LIEALTILOAN	ADL IO			87TH AVE		
SPRING MILL HEALTH CAMPUS			MERKI	LLVILLE, IN 46410			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0505 SS=D	483.75(j)(2)(ii) PROMPTLY NOT RESULTS The facility must pattending physicial Based on record facility failed to notification of lacompleted in a tiresidents in the same (Residents #E, #) Finding include: 1. The record for reviewed on 10/2 resident's diagnor not limited to, cereive (stroke), high bloanemia, and diabanemia, and diaba	oromptly notify the an of the findings. review and interview, the ensure Physician boratory tests results was mely manner for 3 ample of 6. F, and #G) r Resident #G was 22/12 at 11:40 a.m. The ses included, but were crebral vascular accident bod pressure, chronic	F05		F 505 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Residents F, and G had their labs notific to the physician and changes implemented as ordered. Identification of other resident having the potential to be affected by the same alleged deficient practice and corrective actions taken: Current residents have been audited to ensure labs were notified timely to the physician and changes implemented as ordered. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Licensed nurses have been inserviced on physician notification guidelines policy. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: Director of health services/designee will audit I draws daily for 90 days, then five days a week for 60 days, then three times a week for 3 days, audits will be reviewed during Quality Assurance	E, ed s nts an s eab	11/22/2012
	,	r Resident #F was			during Quality Assurance meeting monthly times six		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764		(X2) MU A. BUIL B. WING	DING	nstruction 00	(X3) DATE COMPL 10/23	ETED	
	PROVIDER OR SUPPLIER		B. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE 37TH AVE LLVILLE, IN 46410	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	resident's diagno not limited to, hi	22/12 at 10:50 a.m. The ses included, but were gh blood pressure, oral vascular disease.			months until substantial compliance is achieved. D November 22, 2012	ate	
	indicated laborat completed on 9/2 a CBC (Complet Chemistry Profil	boratory test results ory tests results were 24/12. The tests included e Blood Count) and e. The record indicated is notified of the results					
	p.m., the Clinica the Physician sho	ed on 10/22/12 at 1:00 I Support Nurse indicated ould be notified of esults in timely manner.					
	reviewed on 10/2 resident's diagno	r Resident #E was 22/12 at 10:30 a.m. The ses included, but were blon cancer, renal failure, ure, and arthritis.					
	indicated a PT/IN 10/8/12. The results were There was no do	boratory test results NR test was completed on PT 44.0 and INR 4.4. cumentation of the notified of the 10/8/12					
	The current facil "Physician Notif	ity policy titled ication Guidelines" was					

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00	(X3) DATE SURVEY COMPLETED			
	155764	A. BUILDING B. WING		10/23/2012			
			ADDRESS, CITY, STATE, ZIP CODE				
NAME OF F	PROVIDER OR SUPPLIER	101 W 87TH AVE					
SPRING	MILL HEALTH CAMPUS	MERRILLVILLE, IN 46410					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE COMPLETION DATE			
TAG	reviewed on 10/22/12 at 1:30 p.m. The	TAG	BEITELEXCIT	DATE			
	policy was dated 12/06/2007. The policy						
	indicated the facility was to ensure the						
	resident's Physician was aware of all						
	diagnostic testing results in a timely						
	manner. The policy indicated normal						
	laboratory may be faxed to the Physician						
	office with a follow up to ensure receipt.						
	The policy also indicated if the facility						
	does not receive a response to abnormal						
	test results within 12 hours, the Nurse on						
	duty was to call the Physician to obtain						
	further instructions.						
	When interviewed on 10/22/12 at 1:00						
	p.m., the Clinical Support Nurse indicated						
	the Physician should be notified of						
	laboratory test results in timely manner.						
	, and the second						
	This federal tag relates to Complaints						
	IN00117692 and IN00118202.						
	3.1-49(f)(2)						
l		ı	l				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155764	B. WING		10/23/2012	
		1		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R		87TH AVE		
SPRING	MILL HEALTH CA	MPUS		LLVILLE, IN 46410		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155764	B. WIN			10/23/	2012
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				87TH AVE		
CDDING	MILL HEALTH CAN	ADLIC			CLVILLE, IN 46410		
SPRING				MEKKI	LLVILLE, IN 404 IO		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F9999							
	STATE RULES		F99	99	The two employees affected b	у	11/22/2012
	3.1-14 PERSON	NEL			this citation were reviewed. The		
					completed and signed their job		
	(a)(7) Fach facil	lity shall maintain current			specific orientation checklist a	nd	
		sonnel records for all			returned it to the HR	A II	
	•				Department/Business Office. persoonel files were audited for		
		personnel records for all			job specific orientation	,,	
	1 3	include the following:			checklists. Any personnel file	to	
	Documentation of	of orientation to the			have been found without a job		
	facility and to the	e job specific skills.			specific orientation checklist w	ere	
					corrected with a signed job		
	This State rule w	as not met as evidenced			specific orientation checklist.	We	
	by:	as not met as evidenced			retrained all hiring managers		
	υy.				and our busienss office on our		
					procedures and expectations t		
		review and interview, the			job specific orientation checklish be returned to the business of		
	facility failed to	ensure job specific			within 30 days from date of hir		
	orientation check	clists were completed as			ED and/or designee will review		
	required for 2 of	5 licensed nurses hired			personnel filles for the next 6		
	in the last 120 da				months to make sure job spec	ific	
	(LPN #3 and LP)				orientation checklist have beer	n	
	(ETTV#5 und ET	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			completed. Results will be		
	E' 1' ' 1 1				reviewed at QA for the next 6		
	Findings include	:			months and as needed		
					thereafter. Date of compliance	.	
	The facility Emp	ployee files for 5 nurses			11/22/12		
	hired in the last	120 day were reviewed on					
	10/23/12 at 2:35	p.m. There was no					
		pecific orientation forms					
	for the following						
	LPN #3- Hired o						
	LPN #4- Hired o	on 8/30/12					
	When interviewe	ed on 10/23/12 at 3:00					
	p.m., the Human	Resource (HR) Staff					
		. ,					

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	of correction identification number: 155764	(X2) MULTIPLE C A. BUILDING B. WING	00	_	
	PROVIDER OR SUPPLIER MILL HEALTH CAMPUS	101 W	f ADDRESS, CITY, STATE, ZIP / 87TH AVE RILLVILLE, IN 46410	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	member indicated the Job Specific orientations should be completed and returned within two weeks. The HR staff member indicated the orientations for the above named nurses had not been received. This state tag relates to Complaint IN00117692. 3.1-14(q)(7)				

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